Shaping America's health care professions: the dramatic rise of multiculturalism

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This is the first in a series of articles addressing the major forces that will shape America's health care professions

Fifty years ago, for the question on the US census form, "What is your race?", 89% of participants checked the box for "White," 10% checked "Negro," and 1% checked the box for the phrase "or what race?"[1] Most experts agree that this census report is largely inaccurate because of the methods employed in its data collection. However, it provides a rough sketch of a United States that would be unrecognizable today. The racial and ethnic composition of the US population is changing at its most dramatic rate since the great wave of immigration at the turn of the 20th century. Persons neither white nor African American constitute almost 18% of the US population today, and this demographic change is escalating.[2] Consider the following:

- The nonwhite US population will reach 32% by 2010 and 47.2% by 2050[2]
- Since 1990, the number of foreign-born residents has increased by 6 million and is currently about 25 million (9.3% of the general population)[3]
- The United States adds 1 million immigrants to its population each year (70% legal, 30% illegal)[2]
- Recent-immigrant and nonwhite populations have a birth rate 50% higher than that of the US white population[3]
- By 2025, the Hispanic population of California will be about 33% greater than its white population[4]
- The US Asian population is expected to grow almost 25% in the next decade[4]

It could be argued that the effect of America's evolution toward multiculturalism will outstrip all other social, economic, and technologic trends. The US health care system will not be exempt from these changes, and it is currently not prepared to manage this increase in racial and ethnic diversity. Our shifting demography threatens to expose the ways in which our nation's medical establishment has failed its nonwhite residents. Three primary criteria for the evaluation of any health care system are the overall health of the population it serves, the accessibility it provides, and the quality of care it delivers. By these standards, the US health care industry is failing its nonwhite communities.

THE HEALTH OF MINORITY POPULATIONS

Compared with the white population, US minority groups are not faring well under our current health care system. Across the nation, nonwhite persons suffer from disease at incidence and mortality rates far higher than those for whites. Age-adjusted mortality rates in California, for example, are 61% higher for African Americans than they are for whites.[5] Black Americans have a 50% greater rate of lung cancer and a 35% greater death rate among cancer victims compared with whites, while African American pregnant women are less likely to receive prenatal care, and African American children are 2-1/2 times more likely to die in their first year and to suffer from malnutrition than their white peers.[6] The African American population is not anomalous in this regard. In comparison with the general population, the incidence of diabetes mellitus in Mexican Americans is 200% greater; compared with whites, Native Americans have an infant mortality that is 50% higher; cervical cancer rates for Hispanic and black women are 200% higher than for white women, and for Vietnamese women these rates are 500% higher.[6] Minorities also report greater stress and hypertension and are more likely to be affected by violence than whites.[7] Overall, the state of affairs regarding the health of nonwhites in the United States is unacceptable.

Aside from hereditary factors, members of racial and ethnic minorities face social obstacles to good health because of their low socioeconomic status and cultural marginalization. Dr Nicole Lurie, Principal Deputy Assistant Secretary of Health at the US Department of Health and Human Services, states this fact unequivocally: "In this country, racial and ethnic minorities by and large are disadvantaged in many regards. As a result, people in minority groups frequently get short-changed not only on the quantity of care they receive, but also the quality."[6(p3)]

Summary points

- The evolution of the United States toward multiculturalism will have profound and lasting effects on our health care delivery system
- Significant discrepancies exist between whites and nonwhites in the incidence of disease and rates of morbidity
- Nonwhites in the United States are more likely than whites to lack health coverage
- The health care industry must continue to strive to eradicate cultural and linguistic barriers to the delivery of quality health care
- Racial and ethnic diversity is critical to the provision of care and the long-term sustainability of our health care system

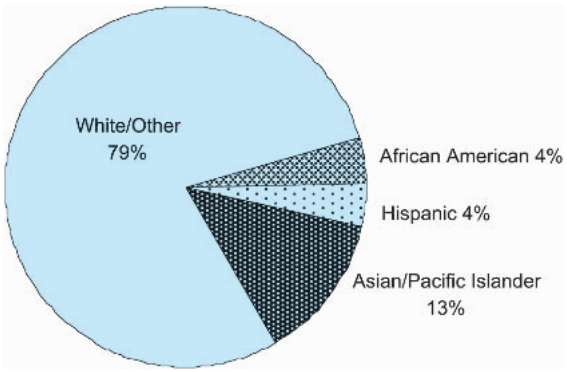

Figure 1 Racial or ethnic mix of California registered nurses, 1997 (from Barnes and Sutherland[9])

ACCESS TO HEALTH CARE FOR NONWHITES

Although people from minority groups are on average less healthy than whites, social determinants limit their access to the health care they need. A national survey of minority health care by the Commonwealth Fund found that 31% of minorities lack medical insurance—twice the rate of white Americans.[7] It also found that nonwhites suffer rates of unemployment that are consistently twice as high as those of whites. Compounding this problem, the survey found, is a lack of insurance coverage for working minorities; when employed, nonwhites are 15% less likely to receive medical insurance from their employers. These problems are intensified by the fact that members of minority groups are also more than twice as likely to live below the poverty level, to never complete high school, and to have an annual family income under $50,000 compared with whites. Collectively, these conditions result in significantly limited health care choices for nonwhites and serious deficiencies in care.

QUALITY OF HEALTH CARE FOR NONWHITES

In addition to the overwhelming evidence of higher incidences of disease and higher mortality, there are additional reasons to conclude that the quality of health care received by nonwhites is inferior. Although studies show that about 60% of whites are satisfied with their health care, the Commonwealth Fund survey found that minority rates of satisfaction are well below 50%. It also reported that, compared with whites, members of minority groups report receiving less respect, empathy, concern for their needs, and accessibility to their physicians. Recent reports indicate that serious discrepancies persist along racial lines in such areas as asthma care[8] and pain management.[5]

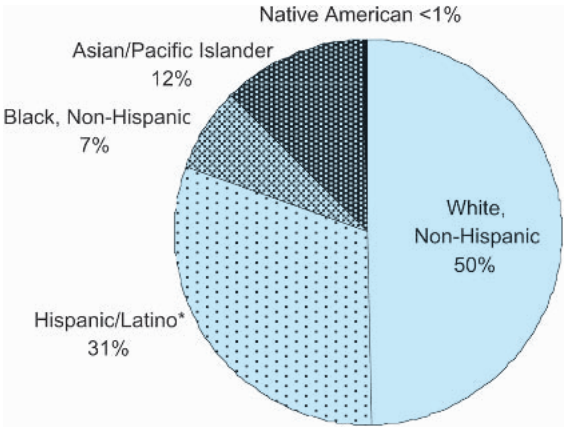

Figure 2 California population by race or ethnicity, 2000 (from California Department of Finance[10]). *Includes Mexican American, other Hispanic, and Puerto Rican.

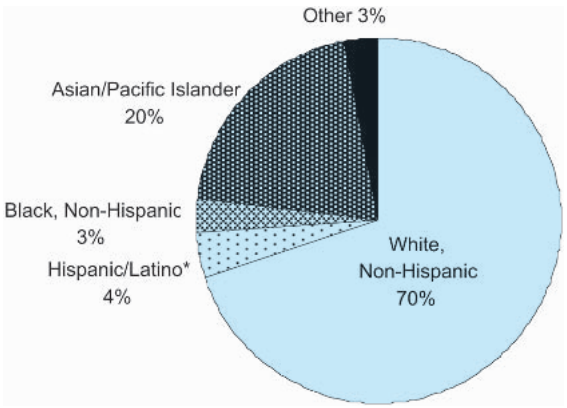

Figure 3 California physicians by race or ethnicity, 2000 (N = 44,555) (from AMA[11]). Active patient care physicians with major professional activity (MPA) of office-based (including locum tenens) and hospital staff; excludes residents, federal physicians, nonclassified MPA, "other" MPA, inactive physicians, and physicians with MPA in non-patient care activities; also excludes 20,543 respondents for whom data on race or ethnicity is unknown. *Includes Mexican American, other Hispanic, and Puerto Rican.

Language barriers also play a role in this cultural divide. Only 75% of minority adults speak English as their primary language; 26% of Hispanic adults and 22% of Asian adults require an interpreter to convey their health care needs.[7]

In addition, despite poorer care and less medical insurance, minorities are more likely to overpay for health services. It is estimated that 40% of nonwhites pay a disproportionately high price for their medical care compared with 26% for whites. Persons of Chinese and Puerto Rican descent have a 50% chance of being overcharged for each medical service they receive.

WHAT CAN BE DONE?

Although the disparity between whites and nonwhites in the quality of health care received may be symptomatic of larger and more complex socioeconomic problems, avenues are available for real improvement concerning this issue. Thoughtful, proactive change regarding our community's health care workforce can offer some solutions. Two promising approaches to this problem are increasing the sensitivity and understanding with respect to the needs

of nonwhite persons ("cultural competence") and diversifying our health care workforce.

The need for increased cultural sensitivity is beginning to be acknowledged within the health care professions. Cultural and linguistic barriers often impede the ability of health care professionals to diagnose and treat diseases and injuries. We must work at facilitating better understanding and communication between patients and the health practitioners charged with their care. In 1999, in a publication on the subject of cultural competence, the American Medical Association stated, "Culturally competent physicians are able to provide patient-centered care by adjusting their attitudes and behaviors to account for the impact of emotional, cultural, social, and psychological issues on their patients' health."[6] Those concerned with the education, training, and regulation of health care workers must recognize that good medicine necessarily includes cultural awareness.

The fostering of cultural sensitivity is one of innumerable benefits derived from a racially and ethnically diverse health care workforce. As it stands, the composition of America's medical labor force does not reflect the heterogeneity of the people it serves (figures 1-3).[9-11] The percentage of American physicians who are Mexican American, African American, Puerto Rican, or Native American (about 8.6%) is less than half of the percentage of the general population that these groups comprise (about 21%).[12] The diversity of the physician assistants and nurses who work beside these physicians is no better—89% of physician assistants[13] and 90% of nurses are white (Moses E, unpublished data, 1996). Recent figures also show that within training programs for the allied health professions, nonwhites are outnumbered 3 to 1.[14]

Compounding this problem of underrepresentation is that the fruits of its remedies are slow to mature. For example, in California 25% of the physician workforce is female. Despite that the sexes have achieved virtual parity within current medical school enrollment, it will be 20 years before women comprise even a third of the state's physician workforce. Simply put, we cannot afford to delay addressing this serious problem.[15]

Besides the obvious issues of social inequality, this lack of representation is deleterious to the nation's health in other ways. One result is the inability of members of racial minorities to procure the medical attention they need. Studies show that the most significant statistical predictor of whether or not physicians will provide care for an underserved population is their race or ethnicity.[6]

In addition to the advantages of increased access to care for minorities and a more culturally informed environment, racial and ethnic diversity also provides a kind of legitimacy for the institutional authority that the medical community holds. To increase diversity within our health system only to see that members of racial minorities care for other members of their respective minority groups is to miss the point. Ideally, our nation's health care institutions should offer cultural sensitivity to all patients. This should extend far beyond the cultural understanding that a provider's ethnicity affords. The real goal of ensuring that our health care industry is ethnically diverse is to see that the needs of all patients are recognized inherently in its policies, practices, and attitudes. The most obvious, and perhaps only, way to see that we are successful in this regard is to produce a health care workforce that is truly representative of its patients.

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